

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 1/23/12
Amount 3780.00

001136

I. IDENTIFICATION

Name PARKWAY MEDICAL Center
Address 1155 Eastern PARKWAY
City/County/Zip Louisville, Jefferson, 40217
Telephone number 502-636-5241
Administrator Joseph E. OKRULICA
Date facility operation began at current address MAY 1973
Date facility began operation under current owner MAY 2003

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>252</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	<input checked="" type="radio"/> Profit	Individual
County	<input type="radio"/> Nonprofit	Partnership
City		<input checked="" type="radio"/> Corporation
<input checked="" type="radio"/> Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

PARKWAY Extended Care Center, INC.
1155 Eastern PARKWAY
Louisville, Ky. 40217

(OVER)

RECEIVED

JAN 23 2012

OFFICE OF INSPECTOR GENERAL

4/31

If facility owned or leased by a corporation, complete the following:

Name of corporation PARKWAY Extended Care Center, Inc.

Address of corporation 1155 Eastern PARKWAY Lou., Ky. 40217

President or Chairman Joseph E. OKRULICA

Vice President _____

Secretary _____

Treasurer Rick Foley

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent
PARKWAY Acquisition, LLC
1155 Eastern PARKWAY
Louisville, Ky. 40217

Management Company
Alton Creek, LLC
1155 Eastern PARKWAY
Louisville, Ky. 40217

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.



Signature of authorized representative

Administrator

Title

1/16/12

Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)